2014 BENEFITS AT A GLANCE

Health Plans	COVA Care	COVA HealthAware	Kaiser Permanente	COVA HDHP
Benefits	**You Receive**	**You Receive**	**You Receive**	**You Receive**
Health Reimbursement Arrangement (HRA) Deposited to your HRA on July 1, 2014	Not available	$600 employee $600 enrolled spouse	Not available	Not available
In-Network Benefits	**You Pay**	**You Pay**	**You Pay**	**You Pay**
Deductible – per plan year				
▪One person	$225	$1,500	None	$1,750
▪Two or more persons	$450	$3,000	None	$3,500
Pharmacy expenses apply toward deductible	No	Yes	No	Yes
Out-of-pocket expense limit – per plan year				
▪One person	$1,500	$3,000	$1,500	$5,000
▪Two or more persons	$3,000	$6,000	$3,000	$10,000
Pharmacy expenses count toward out-of-pocket limit	No	Yes	No	Yes
Doctor's visits				
▪Primary care physician	$25	20% after deductible	$25	20% after deductible
▪Specialist	$40	20% after deductible	$40	20% after deductible
Hospital services				
▪Inpatient	$300 per stay	20% after deductible	$300 per admission	20% after deductible
▪Outpatient	$125 per visit	20% after deductible	$75 per visit	20% after deductible
Emergency room visits	$150 per visit	20% after deductible	$75 per visit	20% after deductible
Ambulance travel	(waived if admitted) 20% after deductible	20% after deductible	(waived if admitted) $50 per service	20% after deductible
Outpatient diagnostic, laboratory, tests,	20% after deductible	20% after deductible	$0 lab, pathology, shots	20% after deductible
injections and x-rays			radiology, diagnostic tests $75 specialty imaging	
Infusion services (includes IV or	20% after deductible	20% after deductible	$25 PCP	20% after deductible
injected chemotherapy)			$40 specialty	
Outpatient therapy visits				
▪Occupational, physical and speech therapy	$25 PCP/$35 specialist	20% after deductible	$40	20% after deductible
▪Chiropractic (30-visit plan year limit per member)	$35	20% after deductible	$40	20% after deductible
Applied behavior analysis (ABA) for autism spectrum disorder—ages 2 through 6 ▪$35,000 annual limit	$25 per service	20% after deductible	$25 per visit	20% after deductible
Behavioral health				
▪Medical and non-medical professional visits	$25	20% after deductible	$12 group/$25 individual	20% after deductible
▪Inpatient residential treatment	**$300 per stay**	**20% after deductible**		**20% after deductible**
▪Intensive outpatient treatment (IOP)	$125 per episode of care	20% after deductible		20% after deductible
Employee Assistance Program (EAP)				
Up to 4 visits per incident	$0	$0	$0	$0
Prescription drugs – mandatory generic				
Retail Pharmacy	*Up to 34-day supply* $15/**$30/$45/$55**	*Up to 34-day supply* 20% after deductible	*Up to 30-day supply* Medical center: $15/$25/$40 Community participating: (3 x copayment for 90 days)	*Up to 34-day supply* 20% after deductible $20/$45/$60
Home Delivery Pharmacy	*Up to 90-day supply* $30/ **$60/$90/$110**	*Up to 90-day supply* 20% after deductible	*Up to 30-day supply* $13/$23/$38 (2 x copayment for 90 days)	*Up to 90-day supply* 20% after deductible
Dental Services				
▪Diagnostic and preventive	$0	$0	See fee schedule	$0
Annual Routine Vision Exam	Not available	$0	Not available	Not available
Annual Routine Hearing Exam	Not available	$0	Not available	Not available

Boxes indicate benefit change .

Plan benefits may change subject to final state budget approval.

2014 BENEFITS AT A GLANCE

In-Network Benefits	COVA Care You Pay	COVA HealthAware You Pay	Kaiser Permanente You Pay	COVA HDHP You Pay
Wellness & preventive services	$0	$0	$0	$0
	Office visits at specified intervals, immunizations, lab and x-rays			
	Annual check-up visit (primary care physician or specialist), immunizations, lab and x-rays			
	Routine gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen (PSA) test, and colorectal cancer screening			
Expanded Dental	***Optional Benefit*:**	***Optional Benefit*:**		***Optional Benefit*:**
▪Maximum benefit – per member	$2,000	$2,000	$1,000	$2,000
▪Deductible	$50/$100/$150	$50/$100/$150	$25 per person	$50/$100/$150
▪Primary (basic) care	20% after deductible	20% after deductible	See fee schedule	20% after deductible
•Complex restorative (inlays, onlays, crowns, dentures, bridgework)	50% after deductible	50% after deductible	See fee schedule	50% after deductible
•Orthodontic	50% no deductible	50% no deductible	See fee schedule	50% no deductible
--Lifetime maximum benefit	$2,000	$2,000	$1,000 (age 19 and under)	$2,000
Routine Vision (*once every plan year*)	***Optional Benefit* :**	***Optional Benefit*:**		Not available
•Routine eye exam	$40	Included in basic plan	$25 PCP/$40 specialist	
•Eyeglass frames	20% off balance after plan pays first $100	20% off balance after plan pays first $100	25% discount	
•Lenses				
--Eyeglass lenses (*standard plastic, single, bifocal or trifocal*) or	$20	$20	25% discount	
--Contact lenses –				
•Conventional** or disposable**	15% off balance after plan pays $100	15% off balance after plan pays $100	15% discount off initial fitting and pair	
•Non-elective**	Balance after plan pays $250	Balance after plan pays $250	15% discount off initial fitting and pair	
			***Pediatric Eyewear* -contact Kaiser**	
Routine Hearing	***Optional Benefit*:** (once every 48 months)			
•Routine hearing exam	$40	Included in basic plan	$25 PCP/$40 specialist	Not available
•Hearing aids and other hearing-aid related services	Balance after plan pays $1,200	Not available	Not available	Not available
•Benefit maximum	$1,200			
Out-of-Network	***Optional Benefit*:** Plan payment reduced by 25%. Provider may balance bill for amount above allowable charge.	Additional deductible out-of-pocket limits apply. 40% coinsurance after deductible. Provider may balance bill for amount above allowable	Not available	Not available

*Options are offered for an additional premium, and may be purchased in combinations as shown on the monthly premiums chart.
**Elective contact lenses are in lieu of eyeglass lenses. Non-elective lenses are covered when eyeglasses are not an option for vision correction.

This is only an overview of your health care benefits. For details, see the appropriate Member Handbook or plan document, or ***www.dhrm.virginia.gov*.**

The program also offers the TRICARE voluntary supplement, which coordinates with federal TRICARE benefits.